STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967773	12/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO BETTER PLACE INC	429 FREEMAN ROAD NW PALM BAY, FL 32907

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A complaint investigation (CCR#2015012724) was conducted on / / at No Better Place Assisted Living Facility, 429 Freeman Road NW, Palm Bay 32907. At the time of the investigation, the facility had deficiencies.

0076 ( )

Based on interview, observation and record review the facility failed to have 1 of 5 sampled resident's documentation in the resident's record of a (#1).

Findings:

1. During a review of Resident#1's incident report on it revealed Resident#1 became unresponsive after shallow breathing due to a in the Resident#1 had a (DRNO). The facility did not have Resident#1's complete record at the facility including the As a result, Staff B and Emergency Medical Services performed ( ) on Resident#1. Resident #1 shortly after that.

2. In an interview on / at 10:45am with the Administrator confirmed Resident#1 had a She stated the was not at the facility at the time of Resident#1's medical incident. She confirmed that the emergency medical staff and the facility staff did not have the available to them at the time of the medical incident.

3. In an interview / at 4:23pm with staff B stated she was not aware that Resident#1 had a as her record was not at the facility and the was not available at the facility at the time of Resident#1's medical incident.

4. In an interview on / at 10:30am with Resident#1's family member stated that Resident#1 had a and the paperwork was not at the facility at time of the incident.

5. In a review of record at the facility on / of Resident#1, it revealed that it contained the incident report and a partially completed Health Assessment. No was located in the file.

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Class III

0160 Records - Facility

Based on interview, observation and record review the facility failed to have 1 of 5 sampled resident's documentation in the resident's record of a (#1).

Findings:
1. During a review of Resident#1's incident report on it revealed Resident#1 became unresponsive after shallow breathing due to a in the . Resident#1 had a (DRNO). The facility did not have Resident#1's complete record at the facility including the . As a result, Staff B and Emergency Medical Services performed ( ) on Resident#1. Resident #1 shortly after that.

2. In an interview on / / at 10:45am with the Administrator stated Resident#1's complete record including the was at the Administrator's other facility at the time of the medical incident and therefore the staff and the medical emergency staff did not have it available to them at the time of the incident.

3. In an interview / at 4:23pm with staff B stated she and the emergency medical staff were not aware that Resident#1 had a as her complete record was not at the facility at the time of the incident.

4. In an interview on / at 10:30am with Resident#1's family member stated that Resident#1 had a and Resident#1's records were not at the facility at time of the medical incident.

5. In a review of Resident#1's record at the facility on / , it revealed t was incomplete and only contained the medical incident report and a partially completed Health Assessment. No was located in the file.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
No Better Place Inc
429 Freeman Road Nw
Palm Bay, FL 32907

RE: CCR #2015012724

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

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